

ALLAN R. KELLY, M.D.
929 COLLEGE AVE. FT. WORTH, TX 76104
817/334-0003

CHART NO.

OFFICE USE

DATE

PATIENT INFORMATION

PATIENT FIRST NAME	MI	LAST NAME	HOME PHONE
ADDRESS	CITY	STATE	ZIP
BIRTHDATE / /	SEX ☐ MALE ☐ FEMALE	SOCIAL SECURITY NO.	CELL PHONE
EMAIL ADDRESS	MARITAL ☐ SINGLE ☐ MARRIED ☐ DIVORCED STATUS ☐ WIDOWED ☐ SEPARATED		
EMPLOYER	EMPLOYMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ RETIRED ☐ UNEMPLOYED ☐ STUDENT		
ADDRESS	CITY	STATE	ZIP

BILLING INFORMATION

-- PLEASE PROVIDE INSURANCE CARDS SO WE MAY MAKE A COPY -- <i>If information listed below is provided on the card, then it is not necessary to complete this section.</i>			
RESPONSIBLE PARTY NAME (IF OTHER THAN PATIENT)		RESPONSIBLE PARTY NAME (IF OTHER THAN PATIENT)	
RELATIONSHIP TO PATIENT		RELATIONSHIP TO PATIENT	
PRIMARY PLAN NAME		SECONDARY PLAN NAME	
PHONE NUMBER	EMPLOYER / GROUP NAME	PHONE NUMBER	EMPLOYER / GROUP NAME
GROUP NUMBER	IDENTIFICATION NUMBER	GROUP NUMBER	IDENTIFICATION NUMBER

PRIVACY NOTIFICATION

As permitted by the Health Insurance Portability and Accountability Act (HIPAA), I understand that my protected health information may be used and disclosed by my physician, office staff, and others outside of this office who are involved in my care and treatment for the purpose of providing health care services.

A copy of the Notice of Privacy Practices for this office is available at www.AllanKellyMD.com

X

Patient Signature

Date

RELEASE OF INFORMATION

- ☐ I authorize Dr. Allan R. Kelly or his staff to electronically mail (email) messages and medical information.
- ☐ I authorize Dr. Allan R. Kelly or his staff to leave messages and to discuss medical information with family members **OR** ☐ I restrict release of information to the following:

Name

Relationship

(OVER)

Allan R. Kelly, MD
929 College Ave.
Fort Worth, TX 76104

Patient Name: _____

EMERGENCY CONTACT

NAME	RELATIONSHIP	HOME PHONE:
ADDRESS	CITY STATE ZIP	WORK PHONE:

ADVANCE DIRECTIVE / POWER OF ATTORNEY

DO YOU HAVE A LIVING WILL or ADVANCE DIRECTIVE? ☐ YES ☐ NO

If Yes, who is named to speak for you and where is the document filed?

DO YOU HAVE A DURABLE POWER OF ATTORNEY? ☐ YES ☐ NO

Person Named _____

Phone Number _____

Alternate Phone _____

ASSIGNMENT OF BENEFITS

I authorize assignment of my insurance benefits to be paid directly to my physician for eligible medical and/or surgical services performed during the course of my treatment. I authorize the release of any medical information needed to determine insurance benefits including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information.

I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company, or any balance due after payments by my Insurance Company.

X

Patient Signature

Date

CONSENT TO TREAT

I consent to necessary medical treatment as recommended by my physician. I understand that insurance may not cover all recommended medical services, such as preventive health exams, immunizations, screening tests, detailed phone consultations, copies of medical records, or preparation of reports, forms, or summaries. I have the opportunity to review specific changes at my request.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization. These authorizations shall remain valid until written notice is given by me revoking said authorization.

X

Patient Signature

Date